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ASSESSING PATIENT PROTECTION LAWS

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I. INTRODUCTION

Professors Hall and Sloan have written a paper that contributes significantly to the literature on managed care regulation.[1] First, their research makes a significant empirical contribution, by compiling, coding and analyzing the fifty states' various patient protection laws to create a database for future observation and study. Second, this research makes an important analytical contribution by describing the extent to which managed care regulation addresses specific defects in the market for managed care services. This comment offers observations about the latter contribution.

By undertaking the task of examining the extent to which patient protection laws address market failures, their article begins to examine whether these regulations do any "good," or, more precisely, whether there is any objective justification for their enactment. Indeed, one would hope this question was asked before the regulations were enacted. Nevertheless, Professors Hall and Sloan provide a paradigm and data, allowing a retrospective look that is instructive for future regulatory efforts. Hall and Sloan conclude that few of the current patient protection laws address the most important failures that characterize this market.[2] Certainly, this observation is both correct and useful as far as it goes. However, this comment suggests two further inquiries.

In Part II, I challenge Professors Hall and Sloan's underlying assumption that if the market for managed care functioned properly—perfectly competitively—then there would be no need for regulatory intervention to achieve optimal resource allocation and distribution. This comment suggests that the purpose of patient protection laws may not be simply to correct market failure. Some patient protection regulation may be justified as serving other

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1. Mark A. Hall & Frank A. Sloan, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS., Winter 2002, at 169.

2. *Id.* at 205-06.

objectives. In Part III, I observe that the theory of relational contracts—as managed care contracts must be correctly viewed—may provide a more complete explanation of the patient protection laws than the market failure approach alone.

II. PROFESSORS HALL AND SLOAN'S ANALYSIS SUMMARIZED

To appreciate Professors Hall and Sloan's analysis, one must begin with the assumption that if the market for managed care health services was perfectly competitive, medical goods and services could be optimally allocated through it, free of any government regulation. The perfectly competitive market alone would achieve optimal levels of production, efficient pricing and allocative efficiency of resources and inputs.[3] It is clear, however, that the market for managed care—like the market for health care generally—is far from a perfectly competitive one. Professors Hall and Sloan identify five key market failures that distort the market for managed care.[4] First, consumers lack information.[5] Managed care goods and services are credence goods; neither consumers nor regulators may easily determine reasonable or equilibrium levels of quality, costs or pricing by any reliably objective method, either before or after the goods are consumed. The information required to contract for goods and services in this market is costly or unavailable; therefore, meaningful comparisons between managed care products are difficult. Moreover, managed care contracts restrict consumers' choice so that the market discipline that results when consumers "vote with their feet" is absent from the managed care market. Second, the managed care insurance market is imperfect due to adverse selection and cream skimming.[6] Insurers are unable both to predict the actuarial value of the losses they insure and to accurately price the product they deliver. Thus, they seek to reduce the quality of the product delivered, or to exclude sicker patients from their plans in order to control costs. Hall and Sloan call this imperfect risk adjustment phenomenon the "Achilles Heel" of managed care and managed competition. The third identified market failure arises from the first two. "Churning" or high member turnover reduces the long-term savings that managed care is designed to achieve through improved preventative care and monitoring.[7] The disparities between employer and employee preferences in the managed care market constitute the fourth market failure Professors Hall and Sloan identify.[8]

3. *See* Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 942 (1963).

4. Hall & Sloan, *supra* note 1, at 172-182.

5. *Id.* at 172-77.

6. *Id.* at 177-79.

7. *Id.* at 179-180.

8. *Id.* at 180-81.

Finally, Hall and Sloan note that it is impossible to deliver the socially optimal level of managed care goods and services because transaction costs associated with determining the marginal benefit and marginal cost of each patient's care are prohibitive.[9] The result has been the industry's imperfect effort to standardize patient care, which is the fifth market failure that Hall and Sloan identify.[10]

Professors Hall and Sloan have tried to simplify and categorize the list of market imperfections that might be addressed by patient protection regulation by using the following catch-all terms: (1) Consumer Ignorance and Asymmetric Information; (2) Imperfect Risk Adjustment; (3) Myopic Orientation of Health Plans; (4) Lack of Consumer Choice; and (5) Standardization of Care.

The next part of the Hall-Sloan analysis utilizes the invaluable database these scholars have created, by coding and cataloging the managed care and patient protection laws from each of the states.[11] Their analysis applies what Altman and Rosman have called the "elective model" of regulation.[12] This regulatory approach is "[t]he least interventionist point of view . . . . [in which the] government only imposes regulations if required to correct market

9. Hall & Sloan, *supra* note 1, at 181-82.

10. Professors Hall and Sloan have identified five defects in the managed care market. All but one have to do with decisions or characteristics of the parties to a managed care contract. While their article does a good job of identifying those market failures that have to do with the characteristics of the market participants themselves, two other categories of market failures are not mentioned: structural market defects and defects due to the very nature of the goods and services distributed in the market.

Structural defects arise simply because of the organizational infrastructure of the subject market itself. In managed care, for instance, the sheer numbers of sellers or individual buyers may prove to be a source of market failure. For example, in rural health markets, the shortage of tertiary care hospital providers structurally impedes perfect competition for managed care services in that sector.

A second category of market failure may arise from the nature of the goods and services themselves that are produced and distributed through a given market. Here, the market failure in the health care industry generally completely overlaps with the defects that hinder perfect competition in the market for managed care services. For example, tertiary care hospitals, reliant on costly medical technology and highly trained specialists, constitute a natural monopoly; therefore, managed care plans are unable to offer the services of these providers in a perfectly competitive environment simply because the product itself is unresponsive to the classic competitive model.

11. These laws include "gag clauses"; "prudent layperson" standards of emergency coverage statutes; tort liability laws; ombudsmen for appeals; independent and external review laws; mandated benefits laws; point of service requirements; medical necessity definitions; limitations on financial incentives available to plan doctors; procedural protections for physicians; and restrictions on indemnification provisions insurers may obtain from physicians.

12. Stuart H. Altman & Brian Rosman, *Introduction: The Philosophy of Regulation*, *in* REGULATING MANAGED CARE, at xxiv (Stuart H. Altman et al. eds., 1999).

failures."[13] Adherents to this model often explain the need for suggested regulations by demonstrating that markets fall short of achieving desired equilibria without the regulation.[14] However, the elective model philosophy does not result in a monolithic approach to regulation. For example, Walter Zelman distinguishes two groups of elective model theorists, explaining "the goal of market-directed regulation then, is not to protect individuals in the face of market failure but to reduce the probability of such failure in the first place."[15]

Hall and Sloan's work is descriptive and, therefore, neither ex post nor a priori. Nevertheless, their posture as elective model theorists is clear and their preference for legislation that prevents market failure is strongly suggested.[16] The analytical approach they take involves matching the list of patient protection regulations they compiled, with the five identified categories of managed care market failures. To the extent that the regulatory measure matches or "fits" with an identifiable failure, that regulation serves a purpose. Absent such a connection between regulation and market defect, Hall and Sloan question the purpose and effectiveness of the subject law. Table 1 summarizes the correlations between patient protection laws and market defects that Hall and Sloan have identified. Table 1 also combines the two important strains of Hall and Sloan's empirical research, to display the core of their analytical contribution.

13. *Id*.

14. *See, e.g*., William Encinosa, *The Economics of Regulatory Mandates on the HMO Market*, 20 J. HEALTH ECON. 85 (2001) (socially optimal levels of quality care and access to specialty care unavailable through markets absent regulation).

15. Walter Zelman, *Regulating Managed Care: An Overview*, *in* REGULATING MANAGED CARE 13 (Stuart H. Altman et al. eds., 1999); *See also* Patricia A. Butler, *The Current Status of State and Federal Regulation*, *in* REGULATING MANAGED CARE 33 (Stuart H. Altman et al. eds., 1999) (describing the regulatory tools state and government may use to "enhance the functioning of a market in health care").

16. *See* Hall & Sloan, *supra* note 1, at 197 ("However, these ex post protections are in tension with increased choice at the point of insurance purchase, which is the market's primary engine.").

TABLE 1

CORRELATIONS BETWEEN MANAGED CARE REGULATIONS AND MARKET FAILURES

Patient Protection Law[17]	*Market Defect Addressed*	*Authors' Comments*
	Liability and Appeal	
Liability (14)	Information Asymmetry, Standardization,[18] Plan/Patient Agency Disparities, Lack of Consumer Choice[19]	"[R]espond[s] directly to market failure resulting from patients' inability to judge quality."[20]
Anti-Indemnity (26)	Information Asymmetry, Physician/Patient Agency Disparities[21]	Responds directly to market failure resulting from patients' inability to judge quality and potential compromises in physicians' professional independence.[22]

17. The number of states having adopted this provision as of 2001 is noted in parenthesis.

18. Hall and Sloan theorize that liability laws "respond directly to the market failure that results from patients' inability to judge quality. . . . In theory, tort liability will encourage plans to provide care and honor their promises up to the level where the marginal cost of extra care equals the marginal benefit of harm avoided." *Id.* at 191.

19. Explaining why the Coase Theorem does not operate in the managed care contract, the authors note that "employers negotiate the primary insurance contract and they may not fully or accurately reflect employees' preferences. . . ." *Id*. at 193.

20. *Id.* at 191.

21. The agency disparity between managed care plans' interests and the interests of the patients who rely upon their decisions represents a market failure rationale that Hall and Sloan argue explains liability provisions addressing negligent coverage decisions. *See id.* at 191-92. However, the agency disparity relevant to liability provisions addressing the quality of medical care is between the physician and the patient. This second disparity is an example of a market failure important to the Hall-Sloan analysis, but not included in the original list of five market failures relevant to their initial analysis.

22. Hall & Sloan, *supra* note 1, at 191-92.

External Review (42)	Information Asymmetry, Standardization, Plan/Patient Agency Disparities, Lack of Consumer Choice,[23] Myopia	Addresses the same issues and shares same justifications as liability provisions.[24]
Funding Ombudsman (18)	Information Asymmetry, Standardization, Plan/Patient Agency Disparities, Lack of Consumer Choice, Myopia	Addresses the same issues and shares same justifications as liability provisions.
	Provider Access Laws	
Any Willing Provider (26)	Imperfect Risk Adjustment, Myopia[25]	Reasonably good fit with significant market failure.

23. The authors conclude that "external review laws address the same issues and share in the same justifications [as liability laws]." *Id.* at 193. The authors further add turnover and patient heterogeneity as justifications for external review laws. "Additional, external review addresses the problem of incomplete or 'relational' contracting that arises from the inability to specify in concrete detail exactly what medical services are covered by insurance." *Id.*

24. *Id.* at 192.

25. Professors Hall and Sloan seem to use "myopia" earlier in the paper to describe managed care plans' shortsighted decisions to drop sick patients from their contracts, but later use the term to describe patients' failure to know or plan ahead for uncertainty of the illnesses that require coverage. *Compare* Hall & Sloan, *supra* note 1, at 194, *with id.* at 195. Therefore, it would seem important to add "Information Asymmetry" to the list of market failures justifying these regulations, based on the authors' explanation:

> Access provisions that are more narrowly tailored to chronic or especially severe conditions address two different concerns: insurers' incentive to provide poor service to those with chronic illness, and healthy consumers' difficulty ex ante in knowing their own likely preferences where they to become ill in the future—in short the problems of risk adjustment and myopia (*or salience*).

Id. at 194 (emphasis added). This same observation applies to the authors' discussion of Freedom of Choice and Continuity of Care provisions as well.

Freedom of Choice (35)	Imperfect Risk Adjustment, Myopia	Reasonably good fit with significant market failure.
Access to OB/GYN without gatekeeper approval. (42)	Lack of Consumer Choice	Broad access provision with weak relationship to market failure.
Specialists (34)	Lack of Consumer Choice	
Continuity of Care (36)	Imperfect Risk Adjustment, Myopia	Reasonably good fit with significant market failure.
Point of Service (23)	Lack of Consumer Choice	Broad access provision with weak relationship to market failure.
	Coverage and Mandates	
Medical Necessity (31)	Strongest justification is to facilitate external review, but should be default provision only.	Weak market justification for specifying uniform definition.
ER Prudent Layperson (47)	Consumer Myopia, Public Goods	Relates reasonably well to these failures.[26]
Drive-Through Delivery (41)	Collective action or adverse selection concerns[27]	Empirical inquiry required to determine strength of link to market failures.

26. Although the authors say the "prudent layperson" standard addresses market failures "reasonably well," elsewhere in the article they describe these provisions as "among the least significant of the different forms of patient protection." *Id*. at 195.

27. Although these were not market failures listed in the first half of the Hall and Sloan article, they are mentioned along with other classic justifications for regulatory intervention into markets. *See id.*

Out-Patient Mastectomy (20)	Collective action or adverse selection concerns[28]	Empirical inquiry required to determine strength of link to market failures.
	Preserving MD Independence	
Physician Incentives (29)	Information Asymmetry, Patient/Provider Agency Imperfection[29]	
Gag Clauses (50)		Least significant of patient protection laws. Symbolic, not substantive.
Physician Due Process (32)	Information Asymmetry, Patient/Provider Agency Imperfection	Address concern that MCO's may compromise physician advice to patients.

Hall and Sloan conclude their analysis with an "overall assessment" finding that the liability, external review and access to specialist provisions address market failures directly, while the other provisions "respond only weakly to legitimate market flaws."[30] Their analysis includes the caution that some provisions may exacerbate or even initiate other market defects if improperly applied, and the observation that regulatory enforcement measures give effect to the laws states have enacted.

28. Hall & Sloan, *supra* note 1, at 195.

29. Hall and Sloan discuss an agency imperfection in the beginning of their article, which describes the dichotomy of interests between employer/purchasers of group health insurers, and the employee/patients they represent. However, they cite a different agency distortion here as a market failure: the distortion between the patient and the provider whose interests might diverge if physicians' judgment is tainted by incentives MCO's offer to act contrary to a patient's best interest. *Id.* at 192.

30. *Id*. at 197.

III. RELATIONAL CONTRACTING THEORY—AN ALTERNATIVE JUSTIFICATION FOR PATIENT PROTECTION LAWS

By choosing the elective analytical model, Hall and Sloan excluded alternative approaches to explain the usefulness of the patient protection laws. The directive model, for example, in which the government creates incentives for market participants to compete directly, may describe the motivation states have for requiring certain disclosures by managed care providers to facilitate consumer comparisons. Similarly, the restrictive and prescriptive models whereby the government substitutes its own preferences for those of market participants, might explain the states' decisions to mandate minimum maternity stays. However, these models may explain the motivations for legislators enacting their provisions. They do not, however, test the efficacy of the statutes that have been enacted. In this sense, Hall and Sloan are looking to do more than these alternative models can deliver. The relational theory of contract, however, is an analytical model that may work to better explain the states' patient protection laws.

Managed care agreements are a paradigmatic example of that unique set of contracts called relational contracts—contracts between parties who, at the time of contracting, cannot know or anticipate fully the eventualities that will trigger their respective obligations under the agreement. Therefore, on a "going forward" basis, throughout the term of the contract, in order to jointly maximize the expected value of a managed care contract, both the provider/payor and the patient/participant must cooperate to minimize costs and maximize services under the agreement. To the extent that the patient wishes to receive high quality medical care, paid for under the contract on a renewable basis, the participant must limit demands for the services the contract offers such that the overall cost of performance by the MCO does not exceed the aggregate premiums paid by plan participants. Similarly, for the MCO to continue to receive premiums, it must stand ready to deliver the expected quality of health care goods and services called for as plan participants demand medical services under the contract, otherwise the plan will be unable to attract these patients year after year. In a real sense, then, each party's return under a managed care contract depends on the other party's cooperative effort.[31] Furthermore, the cooperation the parties seek must occur in a costly environment where information and transaction costs are low, monitoring is ineffective and conflicts of interest are inherent in the relationship. Viewed in this context, managed care contracts are relational and the patient protection legislation regulating them governs these relationships by

31. *See* Robert E. Scott, *A Relational Theory of Secured Financing*, 86 COLUM. L. REV. 901, 918-19 (1986).

a series of default rules that provide objective certainty in an uncertain contracting environment.[32]

The Liability and Appeal rules states have enacted function as generalized rules that reduce the risk of strategic behavior while at the same time inducing parties to share information that will allow them to jointly optimize the benefits of their bargain. Coverage mandates and provider access laws provide customized provisions that define what the parties might reasonably have bargained for in advance, if we assume they are rational actors who had full information at the time they entered the contract. Physician independence rules are more difficult to explain because they insure for the benefit of third parties outside the managed care bargain. However, relational theory adequately explains these rules as limitations on strategic behavior and protections to ensure the parties receive the benefit of their bargain.

It is far outside the scope of this Comment to comprehensively explore the relational contract literature's application to the managed care industry. However, my intention here is to encourage a closer look at this literature's ability to explain these laws, and the way they do and should work, to expand the very significant work that Professors Hall and Sloan have already done.

32. *See generally* Robert E. Scott, *A Relational Theory of Default Rules For Commercial Contracts*, 19 J. LEGAL STUD. 597 (1990).